Community Nursing Among Illicit IV Drug Users

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Abstract: The roots of illicit IV drug use are engrained in the history of many cultures, and are evident at micro to macro levels within many communities. Community nursing involves a broad range of work in diverse settings amongst various populations, including the population of illicit IV drug users; this paper focuses on the historical, current, and future relationship of the Community Health Nurse (CHN) amongst this population.

Keywords: Community Nursing, illicit intravenous drug users, harm reduction

1. History of CHN Among IIDU

IIDU may be any person anywhere exclusive of age, gender, class, race or social status that uses injectable drugs "for which non-medical use has been prohibited" (Degenhardt & Hall, 2012, p.55). Illegal drug use in Canada directly impacts a multitude of health, economic, community and social burdens (Canadian Center on Substance Abuse, 2014; CNA, 2011; Wood et al., 2003) and contributes to increased "morbidity, mortality, disability and health-care costs" (CNA, 2011, p.8). Wood et al. (2003) estimated that "lifetime medical costs (i.e., direct taxpayer-funded dollars) of each case of HIV infection among injection drug users is approximately $150 000" (p.128). Although illicit IV drug users (IIDU) may only be a small percentage of the Canadian population, hospital admissions, healthcare costs, and social harms from blood-borne diseases, soft tissue infections, overdose, stigma, violence and criminalization makes this population a priority for community health nurses (CHN) (Wood et al, 2003; CNA, 2011).

According to the Canadian Drug Policy Coalition (CDPC) (2011), "substance use has been with us since the dawn of time and will continue to be a part of our culture" (para. 1), and it "can be found in all sectors of the Canadian population" (CNA, 2011, p.7), causing an array of disability, morbidity and mortality (CNA, 2011) which CHN are often exposed to. Neale (2008) stated that numerous factors contributing to low socioeconomic status including but not limited to poor mental health, abuse, broken families, trauma, poor coping skills, minimal education, physical health issues, homelessness, incarceration, poverty. These factors may all contribute to the cocktail that results in marginalized populations of IIDU. With these components in mind, as well as the information bared earlier regarding the health, social and economic consequences of IIDU, the need for public health measures becomes clear, such as

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community health nursing (a branch of public health nursing) which provides care to this hard to reach population. CHN were and still are crucial to the health promotion, prevention and population health of Canadians.

Savage and Kub (2009) claimed that, "The clear relationship between public health and nursing began in the 19th century and continues today" (p.2847). Florence Nightingale, often referred to as the founder of modern nursing, was a pioneer of "epidemiology…prevention and public health science" (Savage & Kub, 2009, p.2844). Nightingale unveiled a new understanding of the relationship of social conditions/environments and individual/population health. She shared this cause and effect discovery with others and built the modern day practice of nursing, which has impacted the current public health and CHN practice (Hardill, 2006). With this in mind, the concept of nursing outreach programs to target marginalized populations such as IIDU was put into effect, and in the late 20th century 'street nursing' became more recognized. It was the CHN that were at the forefront of this style of outreach nursing and often CHN became the first point of access for IIDU in urban centers (Hardill, 2006). Hardill explained that CHN were quick to respond with solutions to various consequences of IIDU, such as the HIV/AIDS epidemic, and in the 1980's CHN created the AIDS Prevention Street Nurse Program in Vancouver, BC. From this time, CHN have been involved with IIDU by promoting equity and access to healthcare at the street level, maintaining outreach programs that actively seek out IIDU in the community, providing healthcare services and access to resources, harm reduction programs (primary prevention), screening for blood borne illness (secondary prevention), HIV and HCV treatments (tertiary prevention) and safe injecting facilities such as Insite in Vancouver, BC (CDPC, 2011). As with most healthcare delivery systems in Canada, provincial and federal legislation governed and continues to govern healthcare funding and initiatives, including outreach programs that target populations of IIDU; as a result, legislative changes in Canada surrounding drug policies affected and still are affecting CHN and the relationship they have with the population of IIDU.

2. History of Canadian Drug Policies Affecting CHN and IIDU

The Canadian Nurses Association (2011) *Harm Reduction and Currently Illegal Drugs* document outlines a comprehensive history of Canadian national and provincial drug strategies that date back to 1987 and bring us to modern day. "Prevention, treatment and reduction of the harms of substance use" (CNA, 2011, p. 24) were the fundamental goals of 'Canada's Drug Strategy' at this time and governed initiatives taken to meet these goals countrywide. In 1998, Canadians saw the birth of the four-pillar drug strategy that was mainly led by Health Canada and included, "education and prevention, treatment and rehabilitation, harm reduction, and enforcement and control" (CNA, 2011, p.24). A broad definition of harm reduction by the CNA (2011) is the act of reducing negative outcomes of risky behaviour, with a public health focus on client safety and mortality prevention without insisting abstinence of

substance use. Harm reduction approaches were meant to complement the prevention and treatment aspects of the four-pillar concept at the time. In 2007 the 'National Anti-Drug Strategy', which is the most current, replaced the 'Canada Drug Strategy' and included only three of the previous four drug strategy pillars. Harm reduction was removed from the national policy, and became a "collaborative effort involving the Department of Justice, Public Safety Canada and Health Canada" (CNA, 2011, p.25). It was at this time that individual provinces and health ministries became concerned at the lack of harm reduction in federal anti-drug strategies, and so forth chose to embrace harm reduction policies at a provincial level. While this may not have been addressed at a provincial level across Canada, provinces such as British Columbia adopted harm reduction policy and the BC Ministry of Health developed harm reduction initiatives that have successfully led the way to in creating positive harm reduction programs, such as the supervised injection site in Vancouver, BC (CNA, 2011). A cause of this shift away from national harm reduction initiatives may be due to individual morals and ideologies versus recent research, facts and statistics, which I believe need to be confronted in order to maintain ethical practice in nursing to promote and advocate safe, equal and healthy public policies that govern the health of IIDU.

3. Health Care Challenges Unique to IIDU

Stamler and Yiu (2011) stated that health is a product of an individual's social context. According to the Community Health Nurses of Canada (CHNC) (2011), "the determinants of health are the individual and collective factors and conditions affecting health status" (p.5). Stamler and Yiu (2011) recognized that social determinants of health such as "age, gender, education, geography, lifestyle, attributes, and beliefs" (p.435) influence substance use patterns in individuals. IIDU face many unique challenges involving almost all social determinants of health at some point. Neale (2008) stated that IIDU have increasingly complex health needs, and yet they are a population that encounters multiple barriers when accessing services. In this paper I will be focusing on the social determinant of housing and how it is affects IIDU.

Housing is a key social determinant of health, and especially so in vulnerable populations such as IIDU. The CNA (2011) stated that negative consequences of IIDU may be exacerbated by an individual's living environment, and an increase in poor health may result due to IIDU experiencing homelessness. Neale (2008) pointed out that homelessness includes living conditions such as street living, but also living in a tent or temporary accommodation. She stated that temporary forms of housing are often overcrowded, unsecure and unhygienic. In the simplest terms, Neale explained that a "risk factor for homelessness is substance misuse and…[a] risk factor for problematic drug use is homelessness" (p.432). Futhermore, a study by Fischer et al. (2005) found that not only did the population of IIDU experience increased physical and mental health problems, but also that many of them experienced social

marginalization as a result of lack of housing. The authors claimed that IIDU carried the highest level of stigma due to the multitude of intersecting factors that leave them vulnerable to judgement by society, such as illicit IV drug use and homelessness on top of that.

Neale stated that among the various barriers that IIDU may encounter when trying to access adequate housing, issues like lack of education about the services/resources that are available, and also strict exclusion criteria are often problematic. These issues IIDU face when attempting to access housing have left many of them homeless; consequently, not only does this population remain vulnerable to lack of safe adequate housing, but also to other key social determinants of health like accessing and utilising healthcare services. Having a home address is something many people in Canada take for granted, and it is a critical factor in determining how effective healthcare measures and efforts are delivered. For example if a healthcare provider has no permanent address to find a client, it makes it difficult for them to monitor clients, provide necessary treatments and give safe and consistent quality care. In efforts to combat this issue there are many outreach/street clinics providing interdisciplinary healthcare services available in Canadian cities/towns for individuals with no house address, unfortunately further barriers such as compliance with clinic hours and strict appointment times, and also unpredictable day to day life for IIDU have proven problematic (Neale, 2008).

Another issue that should not be overlooked is the correlation of homelessness and increased rates of public IV drug injecting (Debeck et al., 2009). Debeck et al. (2009) believed that public injecting led to risky behaviours such as needle sharing, lack of filter usage, hasty injection and possible risky sexual activity. Consequently, public injection puts an individual at greater health risks such as skin abscesses, vein damage, blood-borne pathogens such as HIV/AIDS & hepatitis B & C, STIs, cotton fever, overdose etc. (Debeck et al., 2009). Furthermore, Kru¨si, Fast, Small, Wood, & Kerr (2010) described the housing challenges that youth of this population faced as including: difficulties navigating the welfare and housing systems, high rent prices, discrimination when applying for permanent housing, over-restrictive government shelters with unattainable stipulations and the unrealistic living conditions of single room occupancy (SRO) accommodations. To conclude, the CNA (2011) claimed that social determinants of health, such as unstable housing, may predict IV drug use, and also shape the harms that IV drug use results in, such as poor health. An overwhelming opinion in all the literature has been a focus on not just preventing, treating and enforcing drug laws, but also to recognize, address and confront social policies that ignore social determinants of health such as housing, to reduce vulnerability among the population of IIDU.

4. The Current Picture: CHN Role and Standards of Practice

Balfour (2013) claimed that by 2020, there will be a significant shift from health maintenance (ie. nursing in hospitals), to health promotion, prevention and population health (ie. public health nurses

and CHN). According to Balfour (2013) by this time period 60% of Canadian nurses will be involved with public and community health. On top of that fact, CHN play an important role in delivering care to marginalized populations such as IIDU. CHN across Canada are involved with this particular population through activities, such as individual nursing practice, advocating for healthcare delivery access equity and also promoting healthy public policies (CNA, 2005). The CHNC (2011) stated CHN must "promote, protect, [and] preserve the health of individuals…[and] populations in the settings where they live, work, learn, worship and play in an ongoing and/or episodic process" (p.4). Stamler and Yiu (2011) stated that the impacts of IIDU on individuals or groups are "often seen first-hand by the community health nurse" (p.434). Hardill (2006) explained that the role CHN play when dealing with IIDU is a trilogy of factors including: 1) providing primary care 2) advocating for clients within the healthcare system, and 3) advocating for clients at a political level.

CHN across the country currently provide primary care for IIDU in a variety of settings, such as hospitals, street outreach programs or urban street clinics that are accessible for this population. Typically these types of clinics, and this type of care is focused on primary health care services such as primary care and harm reduction, secondary (ie. screening for blood-borne infections) and tertiary (blood-borne infection treatment) prevention strategies. For example, CHN collaborate with the British Columbia Ministry of Health to implement harm reduction at clinics such as Insite through Vancouver Coastal Health in Vancouver, BC. CHN at this particular clinic have seen first hand the positive outcomes of harm reduction strategies among IIDU, as well as the local community (Vancouver Coastal Health, 2013). Other examples of CHN implementing harm reduction strategies to populations of IIDU include nurses with backpacks full of medications and harm reduction supplies walking the streets to actively seek out the basic health needs of this population.

CHN are also responsible for providing a voice in the community for vulnerable populations such as IIDU. CHN are often the primary point of access for this population and help advocate for access and equity in the local healthcare system in a variety of ways, such as providing transportation to/from appointments and hospital emergency visits. CHN often collaborate with various other community groups to advocate for this population (For example, Kelowna's Partners in Healthy Downtowns). Furthermore, CHN currently provide access to community methadone clinics, rehabilitation services, harm reduction programs and take home naloxone programs. CHN advocate for IIDU in the healthcare system by having direct daily contact with the population and attempting to create community change, development and empowerment amongst this group.

Finally, CHN have the ability to advocate for clients at a political level. This is perhaps the most challenging role as it encompasses all five of the primary health care principles of accessibility (equity), public participation, intersectoral collaboration (public policy), appropriate technology (capacity) and health

promotion (reorientation of health services) (Balfour, 2013). Hardill (2006) is of the opinion that "political work is an essential component of street nursing" (p.95). Stamler and Yiu (2011) contend that harm reduction is a vital policy that allows CHN to participate in reducing drug related harms to individuals or communities without requiring the IIDU to abstain completely. British Columbia Center for Disease Control (2014) research reports indicate that harm reduction interventions have been successful in Vancouver for reducing crime, overdose, HIV/AIDS, HCV, public injecting, unemployment rates as well as increasing education opportunities among IIDU.

CHN must advocate at a political level to ensure that effective health strategies (such as harm reduction) are provided, assessed/evaluated, and properly implemented. This requires that the CHNC (2011) Standard of Practice #6: Access and Equity be utilized (ie. access to harm reduction for IIDU populations), and I believe this presents the biggest ethical challenge for CHN when dealing with this population. The CNA Standard 6 requires the CHN to "advocate for healthy public policy and social justice by participating in legislative and policy-making activities that influence determinants of health and access to services" (p.21). In my personal experience as a nursing student, I feel extremely unprepared to embark on such a huge endeavor. Nursing students are taught to nurse and care for the sick and vulnerable, but have very limited education, knowledge and practice when dealing with public policy and legislative issues. Recent research indicating the importance of addressing social determinants of health in the context of health policy is a vital factor in the ability for CHN to provide essential care to IIDU, and yet it is a task that many nursing students, and future CHN may be unfamiliar with.

One of my personal biggest fears as a nurse is attempting to engage policy stake-holders (such as CEO's and politicians) to adopt health and social policies such as harm reduction, but knowing that the majority of public opinion may not agree or even fear the concept (ie. fear that needle exchanges will promote IV drug use) even in light of research that proves otherwise (CNA, 2011). Perhaps the toughest issue CHN may have to face is the ignorance and feeling of futility that may result as a consequence of taking on such a big and controversial issue such as embracing harm reduction strategies. Stamler and Yiu (2011) claim that key stakeholders' support is essential amongst communities and politics for a health program or philosophy to be successful; consequently, if key stakeholders do not buy-in (see the value), then the public may not buy-in either. In order for CHN to ensure support from the individuals/groups necessary, he/she must be an effective communicator and understand the history and research regarding the population and the strategies being proposed. It demands higher, broader education, experience and motivation; consequently, making it a huge challenge to CHN.

5. Future of CHN with IIDU

Currently CHN play a significant role among IIDU in communities whether it be on a personal care basis or a broader level,

such as advocating for healthy public policy to reduce barriers and promote equity to accessing essential healthcare needs. In my opinion, I believe the most important factor shaping the future of CHN with IIDU is in promoting healthy public policy provincially and nationally in regards to harm reduction strategies. I am personally alarmed at the exclusion of harm reduction from the current Canadian National Anti-Drug Strategy. This shift towards emphasizing prevention, treatment and especially crime enforcement versus harm reduction, especially in light of recent research endorsed by a plethora of organizations including the CNA (2011) and Vancouver Coastal Health (2013), seems like a downstream, regressive approach. The statement by the CNA (2011) resonates with me:

> In spite of the evidence supporting the effectiveness, safety and cost-effectiveness of needle distribution and recovery services, these services often face opposition that results in limitations on the delivery of services and, in some cases, discontinuation of services (p.30).

I am shocked that public opinion and ideals outweigh the basic needs of vulnerable populations such as IIDU, but respectfully acknowledge the need to get creative and initiate measures to properly educate the public. Because CHN are often respected members of the community, and because CHN have such a special opportunity to engage with this hard to reach population, they are in the unique position to take on such a big and important task. As the CNA (2011) stated, "The values of harm reduction are consistent with the values guiding professional ethical nursing practice as outlined in CNA's *Code of Ethics for Registered Nurses"* (p.14), and this is the future direction I foresee for CHN working with IIDU.

6. Conclusion

Throughout this paper I have reviewed the history of IIDU and the historical relationship that CHN have had with this population, as well as the history of Canadian National/Provincial Drug policies. Social challenges, such as homelessness contributing to the cause and effect of this marginalized population were recognized, and the importance of confronting social determinants of health when considering vulnerable populations, such as IIDU was noted. Currently CHN are crucial players in building relationships with this population, but are faced with many challenges; perhaps the biggest challenge surrounds development of social policy that positively affects healthcare access. Educating the public, as well as politicians and other stakeholders, in harm reduction benefits (health, economical, judicial, social etc.) is a key future endeavour that I believe CHN will play a strong role in. It is my hope to one day be a part of a collaborative effort by health professionals (including CHN), allied health professionals and politicians to once again house harm reduction as part of the National Anti-Drug Strategy.

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